



EMERGENCY OUTREACH NAVIGATIONAL AND BRIEF SCREENING GUIDELINES FOR WORKING IN LARGE GROUP SETTINGS FOLLOWING CATASTROPHIC EVENTS

Bruce H. Young, LCSW

When a community-wide catastrophe occurs, emergency mental health services are often delivered in settings where large groups of survivors have congregated to receive information and apply for relief benefits. Community settings where outreach services are delivered include disaster relief service centers, shelters, family assistance centers, community centers, schools, hotel conference rooms, etc. To an untrained emergency mental health worker, such settings present the challenge of having to deliver unfamiliar services in unconventional surroundings in limited blocks of time to many individuals – the majority of whom may be ambivalent or resistant to receiving mental health services. Working effectively in these settings requires that emergency mental health responders modify conventional clinical skills and learn efficient and brief methods to engage and screen survivors. Often, only 10-30 minutes can be spent with any one individual when the ratio of survivors to mental health workers is high. To date, models and practice guidelines to help emergency mental health responders work effectively and efficiently in such settings are described in a limited number of training manuals (1-4).

In this brief article, one such model for delivering outreach emergency mental health services in large group settings is described. The model originally appeared in Disaster Mental Health Services: A Guidebook for Clinicians and Administrators (2). It is presented here with revision, taking into account the growing concern regarding the potential adverse effects of soliciting detailed trauma narration outside a context of on-going treatment and the increasing recognition that single-session interventions are unlikely to prevent long-term adjustment problems (5,6).

The primary mission of outreach emergency mental health services is to identify, support, and refer individuals who may have difficulty recovering on their own. This objective is accomplished by: a) providing information and reassurance; b) practical help with problem solving; c) screening for risk associated with adverse mental health outcomes; and d) referring survivors who may benefit from more in-depth support to appropriate services. Delivering disaster mental health services is best understood in the context of *when*, *where*, and with *whom* interventions take place (see 2). For purposes of this article, *when* refers to the emergency phase or first three weeks following the onset of a catastrophe, *where* refers to a community setting, and *whom* refers to non-injured ambulatory adults 21-65 years of age.



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SIX-STEP NAVIGATIONAL GUIDE TO WORKING IN LARGE GROUP SETTINGS

1. Contact setting manager

Upon arriving at an assigned site, it is not uncommon to encounter some form of “structured chaos.” An important first step is to make contact with the site manager and provide a brief overview of emergency mental health services objectives. Ask the manager about any particular concerns or needs, and expectations or perceptions about mental health services. Let the manager know how long you will be there. Have fact sheets and handouts about stress reactions, self-care, and community resources ready to give to survivors.

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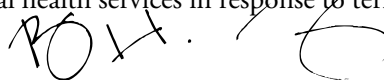
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FROM THE EDITOR...

In this issue, the Clinical Quarterly continues its series of articles about emergency mental health services in response to catastrophic events. In view of government warnings about the inevitability of future terrorist attacks, I've taken license to offer guidelines for providing emergency outreach services in hope that the strategies described will be useful, especially to clinicians who await introductory emergency mental health training. I'm in debt to Dr. Fran Norris, whose recent review of twenty years of disaster research helped to update my referencing of known risk factors. Of course, the guidelines offered here (and other related clinical guidelines that are available on our website ncptsd.org), are not substitutes for formal training. Although an increasing number of clinicians are interested in becoming prepared to respond to national emergencies, publicly funded programs that are available for such training (*before* a disaster occurs) are few. The American Red Cross offers training to licensed mental health professionals (please contact the Red Cross chapter in your community for further information). NC-PTSD also delivers a two day training for VA and other federal and state agencies, including the Department of Defense (please contact: ncptsd@bruceyoung.net for further information). Clearly, it is in the public interest that initiatives be undertaken to develop a much larger standby cadre of trained emergency mental health clinicians as well as community-based clinicians trained to treat the long-term effects of terrorism and weapons of mass destruction.

It is not uncommon for individuals suffering from post-traumatic stress disorder to also have significant current life stressors (e.g., financial/vocational, health, interpersonal, and substance abuse problems). Generally speaking, current practice guidelines suggest such cases benefit from addressing here and now concerns, problem solving and stress management capacities/strategies, social support, and cognitions/reactions associated with the traumatic event. However, some patients' histories include significant developmental deficits that require even more complex strategic treatment planning. In our second featured article, Dr. Steven Gold shares his treatment approach of contextual therapy in which he thoughtfully addresses the treatment implications for patients who have been reared in dysfunctional families. Dr. Gold's suggestions on how to organize PTSD-related treatment with such patients are practical and may be applicable to many veterans seeking VA treatment.

In forthcoming issues, the CQ will feature articles about medication used in treatment of PTSD, treating panic disorder in veterans, treatment of sexual assault, and articles related to mental health services in response to terrorism.



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EMERGENCY OUTREACH GUIDELINES

2. Observe setting

Before engaging survivors, resist the urgency to jump right in. Take time to survey the environment. Evaluate the access to food and water, noise levels (can older adults easily hear conversation?), and seating arrangements (have seats been arranged to facilitate conversation and support among survivors?). Look to see if there are designated areas for children and quiet areas for people who need calm. Is there a bulletin board and a table for informational handouts? If there is a television in the setting, observe or inquire about how often the selected channels are covering traumatic aspects of the event. Use diplomacy to suggest changes in the environment that may reduce stress, facilitate support, and protect people from being exposed to further traumatic stimuli (e.g., suggest that television coverage of the event be limited to specific time slots and that children be protected from viewing catastrophic images).

3. Engage survivors

Offering mental health services and support to people who are not looking for such assistance or who may be ambivalent or resistant to receiving such help is challenging. To engage survivors, look for opportunities to be helpful (e.g., serving food, passing out supplies) and use informal conversation to establish rapport.

Sample icebreakers:

“Hi, my name is _____ I work with emergency mental health services....

May I get you a soft drink or something else?” -or -

“How long have you been waiting to speak with a relief worker?” -or -

“When did you arrive here?” -or -

“Have you been able to talk with your family or friends?”

Next, address an immediate concern, e.g.,

“What do you (or your family) need most right now?”

“How are your kids doing?”

Once rapport is established, screening for risk can begin.

4. Screen survivors for risk factors associated with adverse mental health outcomes

Risk assessment is achieved using informal, but structured conversation, with topics corresponding to post-disaster, within-disaster, and pre-disaster risk factors (Table 1). Because survivors have imminent practical concerns, assessment is best begun with conversational topics related to *present concerns* (i.e., post-disaster factors) followed by questions about the within-disaster experience and pre-disaster factors.

Risk factors may overlap, interact, and combine to create increased risk e.g., severity of exposure (within-disaster risk factor) may result in lower perceived social support (post-disaster risk factor).

Table 1. Risk factors associated with adverse mental health outcomes¹

Post-disaster factors

Resource deterioration (7-9)
 Social support deterioration (9,10)
 Social support increase (11-13)
 Marital distress (14)
 Loss of home/property and financial loss (15-17)
 Decline in perceived social support (18-20)
 Alienation and mistrust (21-22)
 Peritraumatic reactions (23-25)
 Avoidance coping (17, 26-27)

Within-disaster factors

Bereavement (28-30)
 Injury (14, 16, 31)
 Severity of exposure (32-34)
 Panic (35-37)
 Horror (26)
 Life threat (10, 14, 16)
 Relocation or displacement (14, 38-39)

Pre-disaster factors

Female gender (40-42)
 Age: Between 40-60 yrs old (43, 44)
 Ethnic minority group membership (33, 45-46)
 Poverty or low socioeconomic status (47-49)
 Presence of exposed children in the home (18, 50-51)
 Psychiatric history (17, 47, 52)

On the following two pages, examples of questions related to post-disaster, within-disaster, and pre-disaster risk factors are presented to guide emergency outreach assessment. There will not be enough time to do a comprehensive assessment, that is, to ask every question. The selection of questions is based on clinical judgment and information reported by the survivor.

1. Because of space limitations, a maximum of three studies is listed for each risk factor. For a comprehensive literature review, see Norris, F. H. (2001). *50,000 disaster victims speak: An empirical review of the empirical literature 1981-2001*. White River Junction, VT: National Center for PTSD.

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Assessing **post-disaster** risk factorsResource loss

- "How badly damaged was your home?"
- "Are you able to continue working?"
- "Do you have enough savings to get through this?"
- "Do you have other property that was badly damaged?"

Coping and support

- "What concerns you the most about what happened to you or someone else you are concerned about?"
- "What do you ordinarily do to manage stress?"
- "Do you believe you can cope with this experience?"
- "What might help you cope with this experience?"
- "How is it for you to talk about your experiences?"
- "Is there anyone in particular you turn to for support?"
- "Are there people around you who support you?"
- "With whom do you live?"

Stress Reactions²

- "Have you been having repeated disturbing memories or thoughts?"
- "Do you have trouble falling asleep?"
- "Have you been having repeated disturbing dreams?"
- "Do you find yourself feeling or acting like you are suddenly reliving the experience?"
- "Do you become very upset or experience heart pounding, or trouble breathing when experiencing reminders of what happened?"
- "Do you avoid thinking or talking about a stressful experience related to what happened?"
- "Do you avoid situations that remind you of the experience?"
- "Do you have trouble remembering important parts of the experience?"
- "Have you lost interest in activities you use to enjoy?"
- "Do you feel distant or cut off from people?"
- "Do you feel emotionally numb and unable to have close feelings for people who are close to you?"
- "Do you feel like your future has been cutoff?"
- "Have you been feeling irritable or having angry outbursts?"
- "Have you been having difficulty concentrating?"
- "Are you watchful and on-guard?"
- "Do you feel jumpy or easily startled?"

Caveat: Asking survivors to talk about their within-disaster experience may result in their becoming overwhelmed by distressing recollections and feelings. Though such reactions might be informative to the clinician with regard to risk assessment, in these settings it is important to keep distressing reactions from becoming too intense. This can be accomplished by not probing for detail and, when necessary, redirecting the survivor's attention (Table 2).

2. Adapted from the PCL-C for DSM-IV (1994), Weathers, Litz, Huska, & Keane, NC-PTSD

Assessing **within-disaster** risk factorsExposure and Separation from Family

- "Where were you when _____ happened?"
- "Where was your family when _____ happened?"
- "What did you do when _____ happened?"
- "Were you afraid for your life?"

Do not probe for sensory detail (e.g., sights, sounds, smells).

Bereavement

- "Do you know anyone who was killed or injured?"
- (for guidelines to talk with bereaved, see 4).

Displacement

- "Were you able to return home?"
- "Are you able to continue living in your home?"

Assessing **pre-disaster** factors

In the context of outreach services, it is advisable to discuss risk factors related to pre-existing stress and psychopathology as universal risks (common to anyone) rather than to directly ask about chronic stress or psychiatric history. For example,

"We know from research and from talking with many survivors, that people who have major health or financial concerns prior to a disaster, or who have had to cope with depression, anxiety, schizophrenia, or deal with substance abuse often are more vulnerable after an event like this. The same is true for people who have been previously traumatized. If this is the case for you, you may need to take extra care, and, you may want to talk more at length with a mental health professional about it."

If rapport is established, use clinical judgment in considering whether to ask these kinds of questions:

- "What kind of stress were you having to deal with before all this happened?"
- "Have you ever been through anything traumatic before?"

Table 2. Helping a survivor cope with distressing intrusive thoughts

Begin by acknowledging the person's distress. Gently suggest an activity to redirect the focus of attention to disrupt the flow of intrusive thoughts (e.g., mindful walking, washing face and hands, deep breathing, eating); or consider finding something for the person to hold or to touch, (e.g., a pen, a book, clothing, chair) and ask her or him to describe what each object feels like.

If the person appears to be re-experiencing trauma, orient him or her to environment, date, time.

5. Provide support, reassurance, and information

During the course of conversation, support is given via reflective listening (warmth, empathy, genuineness), information, problem solving suggestions, and reassurance to help reduce self-criticism or worry, particularly about common stress reactions. Be prepared to reframe cognitive distortions related to guilt, helplessness, trust, etc. (see, Table 3). Discuss the warning signs that indicate persistent

Table 3. Examples of distorted cognitions and brief cognitive reframes

Distorted cognitions	Brief cognitive reframes
"I was coward. Because of me several people died."	"You felt afraid and perhaps ashamed, but you might consider that your actions kept you from injury and factors far beyond your control resulted in the deaths that occurred."
"I should have calmed down by now."	"I can understand why you might feel impatient. It takes time to go through something like this. Many other survivors are at the same place you are at this point."
"I was helpless then; I just don't have it in me to help myself or cope with this."	"You felt helpless; now you feel uncertain about your abilities – <i>and</i> your actions helped saved your life; it appears you continue to help yourself do what you need to do and are letting others help you as needed."
"People can't be trusted. I can't trust anyone anymore."	"I can understand you feel let down. Most likely, there will be people you can trust and some that you can't."

problems in adults (Table 4), and if needed, in children and the elderly. Underscore the importance of social support, and the negative effects associated with phobic avoidance of reminders of the event. Inform survivors of the risks associated with chronic stress, previous psychiatric problems, and previous traumatic experiences. Review effective stress management strategies (see, Educational talking points, Table 5). If necessary, begin a referral process. At times, advocacy on behalf of a survivor is appropriate. Close "conversation" with a summary of your impressions (i.e., your judgment of how the person is coping, underscoring what he or she is doing well, and which specific behaviors might place them at risk). Make recommendations about self-care, additional resources, and circumstances that would suggest the importance of getting additional help.

Table 4. Warning signs: Advising survivors about when to seek help

Abuse of alcohol/drugs	
Inability to provide essential self-care (eating, hygiene)	
Inability to work	
Phobic avoidance of reminders	
Persistent inordinate grief	
Frequent episodes of intense inappropriate anger	
Intrusive thoughts	
Overwhelming resource loss	
Severe sleep disruption or frequent nightmares	
Severe unremitting anxiety	
Symptoms of clinical depression	
Symptoms of psychosis	
Significant impaired problem solving ability	
Significant social isolation	
Spiritual/existential despair	
Suicidal ideation	
Note: If any of these problems are identified during assessment, make appropriate referral.	

Table 5. Educational talking points

Well-known traumatic stressors

Life threatening exposure, (duration, intensity, frequency), loss of loved ones, resource loss (property, financial, social support, etc.)

Common stress reactions and their course

Emotional: Anger, anhedonia, emotional numbing, fear, grief, guilt, shame

Cognitive: Confusion, difficult concentration, disorientation, indecisiveness, intrusive thoughts, memory loss, self-blame and negative appraisal, shattered beliefs and assumptions, shortened attention span

Physical: body aches, change in appetite, change in libido, diarrhea, difficult sleep, fatigue, hyperventilation, nausea, racing heartbeat, startle, tension, tremor

Interpersonal: Feelings of rejection, increased conflict, increase distrust, increase use of "controlling" behaviors, withdrawal from social support and social activity

Risk factors associated with adverse mental health outcomes

See pre-disaster, within-disaster, and post-disaster variables associated with adaptation to trauma, Table 1.

Self-care and stress management strategies

Positive coping: Exercise, eating well, receiving and giving social support, relaxation techniques, etc.

Negative coping: Substance abuse, workaholism, social withdrawal, phobic avoidance of reminders of event

Benefits of self-awareness of emotional experience, mindfulness, and selected self-disclosure

Parenting/support guidelines: How to monitor children & other vulnerable family members reactions; how to support children and other family members

Characteristics of recovery: Anticipatory guidance about general course of individual & community recovery

Information about available resources

When and where to seek additional help

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6. Termination at the site

When the allotted time ends, inform the setting manager about your leaving and summarize your activities. If necessary, present your rationale for recommendations about changing specific features in the environment. Before leaving, inquire about how the site manager is coping with his or her managerial responsibilities and personal reactions to the catastrophe. Offer your support. If possible, give estimation of when other mental health professionals will return.

Summary

Working effectively in community settings where large groups of survivors are congregated following a catastrophe is extremely challenging, especially for the untrained emergency responder. Navigational and brief screening guidelines are needed to help emergency mental health professionals quickly identify, support, and refer survivors who may have difficulty recovering on their own. A six-step model outlining methods for engaging, identifying, and supporting survivors at risk for adverse mental health outcomes is described along with essential educational talking points related to survivor self-care and when survivors should seek additional help.

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NEW DIRECTIONS

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**VA/DoD Clinical Practice Guideline for Management of Traumatic Stress**

Harold Kudler, M.D. and Matthew J. Friedman M.D., Ph.D.

The New Direction on which we focus the present column is a new VA/Department of Defense (DoD) project to develop a joint Clinical Practice Guideline (CPG) for the Management of Traumatic Stress. Because of the increasing importance of evidence-based practice guidelines in clinical practice, this initiative is a very significant development.

First, it is useful to briefly review the background for the current project. VA, in collaboration with the Department of Defense (DoD) and other leading professional organizations, has been developing clinical practice guidelines since the early 1990s. In 1997, a joint VA/DoD task force produced a clinical practice guideline (CPG) for depression (available at <http://www.oqp.med.va.gov/cpg/cpg.htm>). PTSD treatment was only addressed when the disorder occurred comorbidly with depression but not as the diagnostic problem of major interest. In 1999, an Expert Consensus Guideline was published (1) in which experts in the field expressed recommendations based on their own clinical impressions and not necessarily on the scientific literature. In 2000, the International Society for Traumatic Stress Studies published its practice guidelines (2) which were based on a rigorous and comprehensive review of the scientific evidence concerning twelve different treatment approaches. And, finally, the American Psychiatric Association has recently convened its own task force to develop a CPG for PTSD treatment. VA defines Clinical Practice Guidelines as recommendations for the performance or exclusion of specific procedures or services for specific disease entities. These recommendations are derived through a rigorous methodological approach that includes a systematic review of the evidence to outline recommended practice. Guidelines are frequently displayed in the form of an algorithm, which is a set of rules, in a flowchart format, for solving a problem in a finite number of steps. Clinical guidelines are seen by many as a potential solution to inefficiency and inappropriate variation in care. However, it is acknowledged that the use of guidelines must always be applied in the context of a provider's clinical judgment for the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly format. They are designed to inform and support clinicians without constraining them.

For the current CPG initiative, LTC Bruce Crow, Psy.D., Madigan Army Medical Center, and Harold Kudler, M.D., Mental Health Coordinator, VISN 6, convened a group of providers, administrators, researchers, and chaplains from VA and DoD in Alexandria, Virginia during the week of July 8th. The project had been initiated by Debby Walder, R.N., M.S.N., Director of Quality and Performance for VA and Kathy Dolter, PhD., LTC, AN, Chief, Outcomes Management & Practice Guideline Project Officer, Quality Management, United States Army. Representatives from Army, Navy, and Air Force, VAMCs, Readjustment Counseling Service, and the National Center for Post-Traumatic Stress Disorder (PTSD) comprised a working group consisting of psychiatrists, primary care physicians, psychologists, nurses, pharmacists, occupational therapists, social workers, counselors, and chaplains. Oded Susskind, M.P.H., a medical education specialist, and a team from ACS Federal Health Care, Inc., the contractor responsible for past joint VA/DoD guideline projects, orchestrated the process.

The goal of the present VA/DoD effort is to create an algorithm to aid field personnel and health care workers in identifying, assessing, and/or treating military men and women and veterans who have survived traumatic events. Such trauma may be related to combat, peacekeeping and humanitarian efforts, disaster response, childhood sexual

abuse, domestic abuse endured prior to or during service, and military sexual trauma. The current project is unique in that it will offer a decision tree for prevention, assessment, and treatment with full annotation across a broad range of posttraumatic disorders.

The combined team had to tackle some daunting issues. For one thing, the research literature on treatment has yet to investigate a number of pertinent questions. For example, it is not clear whether combined treatments (such as psychotherapy with pharmacotherapy) are more effective than either treatment alone. It is not clear whether an effective treatment for combat veterans with PTSD will be equally useful for survivors of another trauma, such as recent sexual assault. And research on treatment of PTSD, with and without other co-morbid disorders, is still in its infancy.

Perhaps the most important landmark decision at this meeting was the team's agreement that it could not achieve its objectives by focussing on PTSD, alone. It was decided that the only appropriate approach to interventions for traumatized men and women in DoD and VA is to also address other posttraumatic problems such as Combat Stress Reaction and other very acute stress responses, Acute Stress Disorder, Acute PTSD, Chronic PTSD, and PTSD with co-morbid Major Depression and/or substance abuse. The team has also raised the question of whether to step outside of the current DSM framework and consider the disorder termed Complex PTSD, in which the elements of PTSD merge with findings more often associated with personality disorder such as persistent difficulties in interpersonal relations, somatization, and profound identity problems. This CPG will also address negative health behaviors known to adversely affect clinical outcomes in those with PTSD.

Whenever possible, the team will formulate recommendations based on research findings but there are many areas in which the team has no choice but to offer its expert consensus as a basis for action. The team is developing a set of outcome measures to ensure that the guidelines have useful impact on practice and health. They are investigating ways of integrating the guidelines within VA's Computerized Patient Records System (CPRS) and creating software compatible with hand-held personal assistant devices. Such electronic tools may make it possible to automate the generation of clinical progress notes in the process of running the CPG algorithm.

The development of the VA/DoD Clinical Practice Guideline for Management of Traumatic Stress will continue over the coming months through a series of conference calls, text distributions, and at least one more face-to-face meeting. Late drafts will be made available for review by VA and DoD staff and by the larger community of interested clinicians, administrators, researchers, consumers and the public at large prior to finalization. Once available, the CPG will be continuously monitored and refined in order to keep it current, credible, and practical. Keep an eye out for further developments.

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WOMEN AND TRAUMA: A CLINICAL FORUM

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Working with Women Veterans: Descriptive and Clinical Considerations

Annabel Prins, Ph.D. and Tina Lee, M.D.

It is estimated that approximately 5 % of veterans today are women and that by the year 2010 this will increase to 10%. Currently, the population of women veterans is estimated to be about 1.2 million (1). Who are these women and what are their trauma-related health care needs? The purpose of this column is to provide some descriptive and clinical information on this growing veteran population.

Demographic data from the US Bureau of Labor Statistics and the VA Women's Health Project informs us that the female veteran population is younger than their male counterparts (2). Their median age is 52 (versus 62) and about 30% are under the age of 40. In addition, over 60% of these women are likely to have a college education and close to 60% are likely to be employed. A significant percent of female veterans are either African-American (12%) or Latina (4%). About two-thirds are not married. The states with the largest number of women veterans are California (151,371), Florida (93,431), Texas (81,688) and New York (62,245).

Close to 50% of women veterans will have had war-time experiences, including exposure to hostile conditions in Vietnam, the Persian Gulf, Somalia, Haiti, and Kosovo. In one of the most comprehensive studies on war-time veterans (i.e., The National Vietnam Veterans Readjustment Study), approximately 27% of war-exposed women veterans suffered from Posttraumatic Stress Disorder (PTSD) sometime during their post-war life (3). This is significantly higher than the life-time prevalence of PTSD in civilian women. Several studies have found that female Vietnam war veterans with PTSD also experience more depression and substance related problems, as well as self-reported physical health problems, than female war veterans without PTSD (3,4).

In addition to war-related trauma, the experience of sexual harassment and sexual assault while in the military is not uncommon. Indeed, 64% of women in all branches of the service have experienced sexual harassment (5), and this number may be even higher (69%) during wartime (6). In the VA Women's Health Project, 55% of female veterans reported experiences with sexual harassment and 23% reported experiencing a sexual assault while in the military (7). Women veterans are also more likely than civilian women to have experienced sexual traumas prior to their military experience. For example, one study found that 25.1% of female Army personnel reported at least one attempted or completed rape prior to the age of 18 (8). The consequences of sexual trauma, like war-trauma, include significant impairments in psychological, physical, and social functioning.

It is estimated that 46% of women who report sexual assault as their most traumatic experience will meet diagnostic criteria for PTSD (9). Indeed, there is preliminary data to suggest that sexual assault while in the military may be more detrimental for women than combat exposure (6). In addition to PTSD, women veterans who report experiencing sexual assault while in the military are more likely to report symptoms of depression (60%) than women veterans without this experience (35%). Similarly, 7% of female veterans who reported a sexual assault while in the military reported symptoms of substance abuse as compared to 4% without this history (7). Despite these findings, there is reason to believe that PTSD may be under-diagnosed in female veterans (9) and that a large percent (40-50%) may not be receiving VA psychiatric services (7).

Dr. Susan Frayne and others have found a strong association between a history of sexual assault in female veterans and self-reported physical health complaints (10). Some of the more common physical consequences of sexual violence include chronic pelvic pain, irritable bowel syndrome, back pain and headaches. It is not uncommon for these women to seek medical attention for their difficulties and to endorse a wide range of health problems. For example, Frayne and her associates found that 26% of women veterans with a military assault history endorsed 12 or more different physical symptoms or conditions. Because sexual assault survivors are more likely to present in medical settings than in mental health clinics (11), it is imperative that screening for trauma and PTSD occur in these settings. The VA has begun to require that both male and female patients be asked about their sexual trauma history as part of their primary care in medical clinics. More specifically, primary care providers are being required to ask about sexual harassment and sexual assault experiences while in the military (e.g., "when you were in the military did you ever have an experience where someone used force or the threat of force to have sexual relations with you against your will?"). Once instituted, these screening questions are likely to result in increased referrals to mental health or PTSD clinics for further assessment and treatment.

Socially, women veterans with a history of sexual harassment or sexual assault are more likely to have had two or more failed marriages and to have greater difficulties with work (12). Social support, especially emotional support (e.g., a trusted confidant), appears to be a significant mediator in the development of PTSD (3). In other words, having someone to talk to and someone who really cares significantly helps women to return to earlier levels of functioning. This may be especially important for work with women veterans whose minority status in the military may have lead to increased isolation and concealment. Indeed, the sense of

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community and empowerment that can be important for the recovery of sexual trauma (13), may be limited or non-existent for women veterans. For these reasons, group therapy or peer-mentored programs may be especially important for women veterans with assault histories.

In 1994, Public-Law 103-446 established the Center for Women Veterans in the Department of Veterans Affairs. The mission of the center is to review VA programs and services for women veterans and to assure that women veterans are receiving benefits and services that are consistent or on par with male veterans. The center provides information to veterans as well as to providers and can be reached at: Center for Women Veterans, Department of Veterans Affairs Central Office (00W), 810 Vermont Avenue, NW, Washington, DC 20420. Telephone: 202-273-6193.

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TREATING COMPLEX TRAUMA CASES: A CONTEXTUAL APPROACH

STEVEN N. GOLD, PH.D.

Expertise in trauma, almost literally, helps us “see” what others may be “blind” to, sensitizing us to the prevalence of traumatic exposure and its possible relation to the difficulties of those who seek therapy. However, like any other construct or conceptual framework, the very lens that helps us focus on and detect trauma and its impact can obscure the presence and relevance of other factors that may be essential to recognize in order to be clinically effective. Once we become aware that a client has a trauma history, it can be difficult not to frame all or most of her or his problems as the sequelae of trauma. As a result, we can easily lose sight of factors other than trauma that may play a pivotal role in the genesis and maintenance of these problems.

Paradoxically, factors beyond and in addition to discrete traumatic events may have an especially prominent influence on the difficulties of those clients with the most extensive or protracted histories, those who are often conceptualized as manifesting “Complex Post-Traumatic Stress Disorder.” Integral to the construct of Complex PTSD is the proposition that intricate, varied, and severe difficulties comprising this disorder are the result of repeated trauma (1). Clients with an extensive history of child abuse are commonly considered to be prototypical of individuals with Complex PTSD (see, e.g., 2, 3).

A little-known but consistent body of empirical literature suggests that many survivors of prolonged child abuse (PCA) grow up in family environments that are controlling, conflict-ridden and low in adaptability and cohesion (4-10). Furthermore, this type of family background appears to make an appreciable contribution to the long term difficulties of PCA survivors independent of that made by the impact of abuse to which they were subjected (7, 11- 13). Moreover, there is evidence that the effect of this type of family atmosphere is to some degree qualitatively distinguishable from that of abuse. Family environments of this type seem to be specifically related to attachment and characterological difficulties (14). These differences generally coincide with the criteria that differentiate Complex PTSD from PTSD.

This apparent differential impact of family environment and of overt abuse is not merely an academic one; it carries substantial practical clinical importance. Trauma disrupts adaptive capacities. For the trauma survivor, therefore, the aim of therapy is to recover extant abilities that have been weakened or made less accessible by the impact of trauma. In contrast, being reared in a chaotic, conflict-ridden, coercive and emotionally unsupportive interpersonal context prevents adaptive capacities from developing in the first place. Addressing and processing traumatic material can restore capacities that have been disrupted by trauma, but cannot be expected to instill capacities that were not previously developed. Therefore, to the extent that having been reared in an ineffective family environment contributes to a particular PCA survivor’s difficulties, therapy will only be successful if those resources that were never present are identified and remediated.

Contextual therapy was specifically designed for PCA survivors in order to address those deficits related to their having been reared in an ineffective family and social context. It was developed at the Trauma Resolution and Integration Program (TRIP), an outpatient treatment program for trauma survivors housed within a university-based, publicly funded community mental health center. The clinical staff of TRIP consists of doctoral level psychology practicum trainees and interns. Founded in 1990, originally TRIP almost exclusively treated adult survivors of childhood sexual abuse. However, four years ago admission criteria were broadened to include survivors of all forms of child abuse and survivors of circumscribed trauma. The latter group was included for training purposes; the intention was for students to see that treatment for survivors of more circumscribed forms of trauma was usually completed within 20, and often considerably less than 12 sessions, in contrast to the long term treatment required for their PCA survivor clients.

However, things did not turn out as planned. When we tried to treat clients reporting recent trauma with exposure-based therapy, we quickly ran into complications. Much more often than not, those who presented complaining of the after effects of a recent traumatic event turned out to have a prior



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Addressing and processing traumatic material can restore capacities that have been disrupted by trauma, but cannot be expected to instill capacities that were not previously developed.

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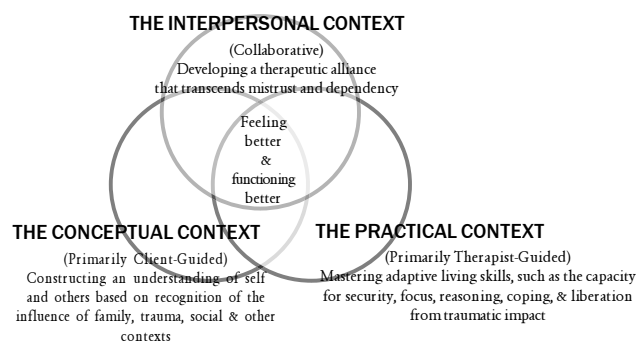
history of repeated trauma and of significantly impaired functioning that long pre-dated the most recent traumatic incident. We came to find that many of these clients described growing up in family environments very similar to those in which the PCA survivors we treated were reared. When we shifted from a trauma-focused to a contextual treatment approach, therefore, therapy proceeded much more productively. It became clear that clients presenting with PCA histories were not the only ones for whom this form of therapy was suitable (15).

For this reason, it is imperative when clients present with a trauma history that therapists not assume that all their difficulties are trauma-related. A thorough exploration of their functioning before the traumatic event (e.g., before exposure to combat), of the presence of earlier traumatic experiences (child abuse) and of the quality of their family of origin environment is indispensable to planning an appropriate course of treatment. At one extreme, an individual reared in a supportive and adaptive family and social context with relatively recent and circumscribed trauma (e.g., a criminal assault within the last six months), even where PTSD symptomatology is fairly severe, is likely to recover rapidly in response to exposure therapy (e.g., Prolonged Exposure or Eye Movement Desensitization and Reprocessing). Conversely, an individual whose family of origin was highly chaotic, conflict-ridden and emotionally inconsistent or detached and who has an extensive trauma history may be at high risk for experiencing marked deterioration in response to exposure-based interventions. Clients of this type, due to their attachment difficulties, gaps in social learning, and maladaptive coping strategies, often find it extremely taxing navigating the routine stressors of daily living. Many of them have never established either the inner capacities (e.g., managing distress, critical judgement) or the external resources (e.g., social support systems, financial stability) to adequately manage ordinary daily stressors. It is not at all surprising, therefore, that those interventions that entail confronting the extraordinary stress evoked by traumatic material are overwhelming to them.

This certainly does not mean that exposure-based interventions never have a place in treatment of these clients. However, if they are not integrated into a broader treatment plan that fosters the acquisition of the capacities needed to productively face and assimilate traumatic material, these same approaches that can be so effective with survivors of more circumscribed trauma can be severely damaging to this clientele. Poorly timed exposure to traumatic material without adequate integration into a more comprehensive plan of treatment often greatly intensifies their distress, diminishes their level of functioning, exacerbates their reliance on addictive and compulsive behaviors, and increases the occurrence of crises.

Consequently, therapists can eventually come to feel discouraged and overwhelmed and to conclude that clients in this spectrum are either not invested in or incapable of improvement, and do their best to avoid working with them. This is extremely unfortunate, because we have seen excellent outcomes with these clients when a treatment approach grounded in a conceptual framework that takes both trauma and family (and larger social) context is employed (16).

Figure 1. The three components of contextual therapy



Contextual therapy consists of three fundamental, integrated components. Although each component may become more or less salient at different phases in the course of treatment, all three play some role at any given point in time. The three components are designed to address the series of deficits and difficulties that are commonly created by growing up in an ineffective family environment, exposure to trauma, and to the complex ways in which the effects of these two factors interact and augment each other. They are:

1 - The Interpersonal Component - Cooperatively guided and negotiated by both therapist and client, this component consists of methods and processes for helping the client, who has often never experienced a sustained relationship based on cooperation and collaboration, develop these interpersonal capacities. A major theme of this component is accommodating and addressing the conflicting forces of dependency and mistrust often engendered by both traumatic experiences and being reared in an ineffective family of origin. This component of treatment also promotes development of the capacities for the establishment and maintenance of appropriate boundaries in a relationship, interpersonal and emotional engagement, and greater acceptance of self and others.

2 - The Cognitive Component - Primarily client-directed, the aim of this component is to promote the development of cognitive understanding of self, others, and current difficulties as reflections of the impact of the client's trauma history, family background, and socio-cultural-political context. The therapist guides the process of exploration in the form of

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Rogerian active listening and Socratic questioning while avoiding directing the content discussed or conclusions reached by the client. This aspect of the cognitive component of contextual therapy is aimed at facilitating development of the client's capacities for critical judgement and independent reasoning.

3 - The Practical Component - This component is primarily therapist-directed. It consists of teaching the client the skills needed for overcoming the adverse impact of trauma and for effective daily living. It is similar to the skills training aspect of dialectical behavior therapy (DBT) (16-17). In fact, at TRIP we combine weekly DBT skills group meetings with weekly individual contextual therapy sessions when we treat PCA survivor clients. The skills comprise prioritized treatment goals. More than one skill is often addressed simultaneously in treatment, but the extent to which a particular skill is focused on depends largely on its priority. The skills are listed in order in Table 1, along with the rationale for the priority assigned to each of them. In addition, the development of the capacity comprising each goal is to a large extent (although not entirely) dependent on the stabilization of the previous capacity. To the extent that a higher priority goal is attained, it will make it easier to work toward those goals with a lower priority, but this does not mean that one cannot begin to work on a goal until attainment of all those goals with a higher priority is reached.

As implied by the Venn diagram in Figure 1, the three components of contextual therapy are overlapping and intimately intertwined, and none of the three is likely to lead to satisfactory therapeutic outcomes in the absence of the other two. The practical or skills component, for instance, is the most concrete of the three major aspects of contextual therapy. It is therefore the easiest to describe and the quickest for clinicians to learn. It may be tempting, therefore, to focus on this aspect of the treatment to the relative exclusion of attending to the other two. However, many clients for whom contextual therapy was developed, due to their attachment difficulties, will enter treatment with intense preoccupations about the therapeutic relationship, such as whether the clinician can be relied upon and will be emotionally responsive and available. These concerns can be so salient that they may interfere with the client's willingness or ability to focus on, practice, and master the concrete techniques comprising the practical component of treatment. Similarly, if sufficient attention is not placed on the cognitive component, clients may not be clear on the need or rationale for mastering these techniques and consequently are likely to either carry them out in a rote manner that will limit their value or to lack the motivation to learn and practice them regularly. Framed in terms of the diagram in Figure 1, these examples illustrate not only that all three components are required for successful treatment to occur, but that it is as important to attend to the interaction between the components (represented by the intersecting areas of the circles in the diagram) as to the components themselves.

Table 1. Prioritized Treatment Goals Comprising the Practical Component of Contextual Therapy

<u>Goal</u>	<u>Rationale for Priority</u>
Development of the capacity for:	
Managing and moderating distress	High levels of distress commonly experienced by PCA survivors <ul style="list-style-type: none"> • increase the likelihood of crises • foster dissociative reactions
Maintaining a sense of continuity and focus on the here and now	Once baseline distress levels are moderated, dissociative states are less likely to be triggered and easier to interrupt. High levels of dissociation commonly experienced by PCA survivors <ul style="list-style-type: none"> • interfere with cognitive processing
Exercising critical judgement and automatic independent reasoning	Once dissociative reactions are less frequent and intense, it is easier to concentrate sufficiently to think through complex issues. Cognitive distortions, conceptual confusion, and reliance on the opinions of others <ul style="list-style-type: none"> • promote reliance on addictive and compulsive behaviors as coping strategies
Breaking maladaptive (i.e., addictive and compulsive) behavior patterns	Once the capacity for critical judgment and reasoning are in place, it becomes easier to cognitively examine and thereby interrupt addictive and compulsive behaviors. Reliance on addictive and compulsive patterns of behavior as coping mechanisms <ul style="list-style-type: none"> • maintain avoidance of confrontation of traumatic material
Confronting traumatic experiences and deconditioning their impact	Once reliance on addictive and compulsive coping strategies is reduced, relapse in response to confronting traumatic material is less likely. Post-traumatic re-experiencing, avoidance, and arousal <ul style="list-style-type: none"> • interfere with management of daily living

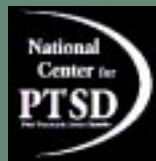
TREATING COMPLEX TRAUMA CASES

Contextual therapy is a new form of treatment, still being developed and refined. Thus far, clinical observation (18) and single case design studies (19) provide some preliminary evidence for positive outcomes in relatively complex cases. Controlled empirical studies assessing its effectiveness, however, have yet to be carried out. This will eventually need to be the standard against which the efficacy of contextual therapy is measured. In the interim, this form of therapy can equip practitioners with an integrated treatment approach for complex cases that incorporates awareness of and responsivity not only to trauma and its sequelae, but also to the role that family and social context often play in creating, shaping, and maintaining the difficulties commonly experienced by survivors of prolonged and repeated trauma.

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NATIONAL CENTER FOR PTSD EDUCATION, TRAINING, & SUPPORT SERVICES

PTSD Assessment Library

Available upon request are selected instruments from our library of assessment and program evaluation tools (with accompanying articles), together with templates describing over 100 trauma-related measures courtesy of Beth Stamm, Ph.D., and Sidran Press. Telephone (650) 493-5000 ext. 22477.

PTSD Article Library

A helpful set of key articles on aspects of PTSD is available to VA or Vet Center clinicians free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Video Library

The Menlo Park Education Team maintains a small videotape lending library exploring topics related to PTSD diagnosis, evaluation, and treatment. Videotapes may be borrowed free of charge. Telephone (650) 493-5000 ext. 22673.

PTSD Program Liaison and Consultation

The Menlo Park Education Team can help VA health care professionals locate needed resources. Services may include assistance in locating relevant articles, locating resource persons, or problem-solving. Staff are available to consult in the areas of PTSD Diagnosis and Treatment, Program Development and Design, Women and Trauma, Relapse Prevention, and with other PTSD-related concerns. Telephone (650) 493-5000 ext. 22977.

National Center for PTSD Web Page

The NC-PTSD Home Page provides a description of activities of the National Center for PTSD and other trauma related information. The world wide web address is: <http://www.ncptsd.org>

PILOTS Database

PILOTS, the only electronic index focused exclusively on the world's literature on PTSD and other mental health consequences of exposure to traumatic events, provides clinicians and researchers with the ability to conduct literature searches on all topics relevant to PTSD. <http://www.ncptsd.org/PILOTS.html>

NC-PTSD Research Quarterly

The *Research Quarterly* reviews recent scientific PTSD literature. Telephone (802) 296-5132 for subscription information.

Disaster Mental Health Training and Consultation

Education staff provide training in disaster mental health services to host federal and state agencies, including psychological first aid and other early interventions, how to work in large group settings, intervention considerations with special populations, and emergency mental health worker self-care. Telephone (650) 493-5000 ext. 22494 or email: ncptsd@bruceyoung.net

Conferences and Training Events

The Menlo Park Education Team provides consultative support for the development of training in PTSD. Services include assistance in finding faculty and designing program content. Telephone (650) 493-5000 ext. 22673.